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Intense Fear, Helplessness, "and" Horror? An Empirical Investigation of *DSM–IV* PTSD Criterion A2

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In the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., *DSM–IV*; American Psychiatric Association [APA]), an experiential response was added to the posttraumatic stress disorder (PTSD) traumatic stressor criterion (Criterion A). In addition to witnessing or experiencing an event involving serious threat to one's life or physical integrity (Criterion A1), a traumatic stressor must also evoke an intensely negative emotional response (Criterion A2), operationalized as "intense fear, helplessness, *or* horror" (emphasis added, p. 428). There has been some question about, but little empirical investigation of, the PTSD predictive value of Criterion A2. Toward this end, a study was conducted to examine differential rates of PTSD among individuals who met Criterion A2 by reporting 1, 2, or all 3 A2 responses. Participants included 205 military personnel, military retirees, and military family members who were receiving services from 4 treatment programs at an army medical center. Forty-three percent of individuals who reported all 3 A2 responses met diagnostic criteria for PTSD; however, only 9% of individuals who reported fewer than 3 A2 responses met criteria for PTSD. The results suggest that the definition of PTSD Criterion A2 may be too broad. A revision or refinement of Criterion A2 in the next edition of the *DSM* may be indicated.

Keywords: PTSD, Criterion A2, diagnosis, trauma response

The Diagnostic and Statistical Manual of Mental Disorders (5th ed., *DSM–V*), circa 2012, presents a major research agenda for academic psychiatry. In this regard, the stress disorders—acute stress disorder (ASD) and posttraumatic stress disorder (PTSD)—are among the diagnostic entities that are undergoing considerable scrutiny—boding the possibility of major changes in *DSM–V* (e.g., Brewin, Andrews, & Rose, 2000; Roemer, Orsillo, Borkovec, & Litz, 1998; Zoellner, Jaycox, Watlington, & Foa, 2003).

To receive a diagnosis of PTSD, an individual must have been exposed to a traumatic event. In *DSM–III–R* (American Psychiatric Association), a traumatic stressor was defined as "an event outside the range of usual human experience and would be markedly distressing to anyone," with examples provided—including serious threat to one's life or physical integrity or serious threat or harm to one's children, spouse, or other close relatives and friends (American Psychiatric Association, 1987, p. 250). In *DSM–IV*, a subjective host response was added to the stressor criterion. In addition to experiencing, witnessing, or confronting an event or events involving actual or threatened death or serious injury, or a threat to the physical integrity of self or others (Criterion A1), a traumatic stressor must also evoke an intensely negative emotional response (Criterion A2). This intensely negative emotional response was operationalized as "intense fear, helplessness, *or* [emphasis added] horror" (American Psychiatric Association, 1994, p. 428).

There has been relatively little empirical study of the PTSD Criterion A2. In an undergraduate sample, Roemer et al. (1998) found that only helplessness was significantly correlated with posttraumatic stress symptoms. In a longitudinal study of victims of violent crime, intense levels of all three emotions predicted later PTSD (Brewin et al., 2000). In a sample of 2,181 adults, the majority of A1 events reported also evoked A2 (Breslau & Kessler, 2001). Events that did not evoke A2 rarely resulted in PTSD, reflecting a high negative predictive value (NPV). However events that met A1 and evoked A2 resulted in PTSD in only 12% of the sample, reflecting a low positive predictive value (PPV) of PTSD Criterion A2.

Maximizing the PTSD PPV of Criterion A2 may carry important implications for use in PTSD screening, and allocation of clinical resources, where it could be of considerable clinical utility to know if a particular combination of A2 responses improves the PPV of A2. By definition, intense fear, helplessness, and horror are considered equally likely to evoke posttraumatic stress—as indicated by the use of the word *or* in the phrase, "intense fear, helplessness, or horror." However, events that evoke all three A2 responses may be more likely to activate posttraumatic stress than events that do not evoke all three aspects of A2. The present study

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was designed to examine the predictive value of A2 and draws on a secondary analysis of data collected for another study.

Method

Participants

The sample was comprised of 205 adults (73 men and 132 women) who were receiving health-related services from four treatment programs at an Army Medical Center. The four treatment program settings were (a) an outpatient psychiatry clinic ($n = 53$), (b) an alcohol abuse treatment program ($n = 51$), (c) a family violence services program ($n = 49$), and (d) a family practice medical clinic ($n = 52$). Ninety-six participants (47%) were active duty military personnel or retirees, and 109 participants (57%) were adult family members of active duty personnel. The men's mean age was 29.39 ($SD = 10.41$) and the women's mean age was 26.80 ($SD = 10.24$). The mean education level of the men was 13.53 years ($SD = 1.86$), and the mean education level of the women was 12.71 years ($SD = 1.42$). Participants' ethnic backgrounds were diverse, including White ($n = 107$), Black ($n = 43$), Mexican ($n = 9$), American Indian ($n = 8$), Native Hawaiian ($n = 5$), Filipino ($n = 4$), and other or mixed ethnicity ($n = 21$).

Regarding recruitment, our sample included only volunteers. Participants were scheduled in two ways. Study participants were solicited by means of flyers posted at various locations throughout the medical center. In addition, staff at the four treatment programs announced the study to program participants, but no specific individuals were encouraged or discouraged from participating in the study. Thus, there was no reason to suggest that there was any systematic difference between program participants who took part and did not take part in the study.

Measures

CAPS. The Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990) is a structured interview for assessing the symptoms of PTSD according to criteria in the *DSM–IV*. The CAPS was found to have very good diagnostic efficiency when judged against the Structured Clinical Interview for the *DSM–III–R* (Weathers et al., 1992).

The CAPS scales were administered by three doctoral students in clinical psychology who were trained to administer the CAPS by Edward Kubany. The assessors were presented a lecture on administration of the CAPS, watched two to four CAPS administration videos, watched Kubany administer the CAPS at least twice, and were observed administering the CAPS at least twice for corrective feedback and to ensure interviewer competence.

TLEQ–C. The Traumatic Life Events Questionnaire—Computerized Version (TLEQ–C; Kubany, Haynes, et al., 2000; Western Psychological Services, 2003) assesses exposure to a broad spectrum of 21 potentially traumatic events. TLEQ items were developed from multiple sources of information to enhance content validity across the domain of important traumatic events. In separate studies with college students, Vietnam veterans, battered women, and substance-abusing men and women, most items possessed adequate to excellent temporal stability. The TLEQ–C is self-administered on a computer. In a sample of 105 individuals receiving services at a family practice medical clinic, overall reports of occurrences and nonoccurrences of events on the TLEQ-C were in 91% agreement with reports on the TLEQ. The mean kappa across 21 events assessed on the TLEQ–C and the TLEQ was .75 (Kubany & Hill, 2004).

PSDS–AC. The PTSD Screening and Diagnostic Scale—Abbreviated Computerized Version (PSDS; Kubany, Leisen, et al., 2000; Western Psychological Services, 2003), formerly the Distressing Event Questionnaire, assesses all six criteria for PTSD in the *DSM–IV* and can be used to assess PTSD according to the *DSM–IV* criteria or by symptom cut-off scores. In four separate samples of physically and/or sexually abused women (total $N = 255$), a PTSD symptom cut-off score of greater than 25 correctly classified the PTSD status (present/absent) of 87% of participants. PSDS symptom scores were correlated .87 with the CAPS, .86 with the Modified PTSD Scale (Falsetti, Resnick, et al., 1993), and .85 with the Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988). The PSDS also exhibited strong convergent validity across ethnic groups. The PSDS–AC is self-administered on a computer and only includes 20 PTSD symptom items. In a sample of 105 individuals receiving services at a family practice medical clinic, scores on the PSDS–AC were correlated .89 with symptom scores on the abbreviated paper-and-pencil version of the PSDS (Kubany & Hill, 2004).

BDI. The BDI is a widely used measure of depression, with well-established reliability and validity (Beck, Steer, & Garbin, 1988).

Trauma-Related Guilt Inventory. The Trauma-Related Guilt Inventory (Kubany et al., 1996) assesses guilt and cognitive and emotional aspects of guilt associated with specified traumatic events. The inventory includes three scales and three subscales, including a Global Guilt Scale, a Distress Scale, a Guilt Cognitions Scale, and three guilt-cognition subscales. Short-term test–retest reliability in samples of college student and combat veterans was very good. The various scales and subscales were significantly correlated with measures of PTSD and depression in both battered woman and combat veteran samples. Only scores on the Global Guilt Scale were used in the present study.

Procedure

The study protocol was approved by the Human Subjects Subcommittee at the Honolulu VA, and by the Human Use Committee at Tripler Army Medical Center. Investigators adhered to the policies for protection of human subjects as prescribed in 45 CFR 46.

The sample included only volunteers. Participants were recruited in two ways. First, study participants were solicited by means of flyers posted at various locations throughout the medical center. Second, program staff at an outpatient psychiatry clinic, an alcohol abuse treatment program, a family violence services program, and a family practice medical clinic announced the study to program participants and invited them to participate in the study. However, no specific individuals were either encouraged or discouraged from participating in the study. Thus, there was no reason to suggest that there was any systematic difference between program participants who took part in the study and those who did not participate.

Participants were scheduled for individual appointments to complete the study. Most completed their participation in the study in less than 2 hr. Participants were offered incentives for their participation; civilians were mailed checks in the amount of $40; military personnel were given vouchers redeemable for merchandise at the Base Exchange.

The data for this study were drawn from a larger study conducted for a different purpose (Kubany, Hill, & Haynes, 1998). PTSD was assessed for the TLEQ-reported event that was the greatest source of current distress. Prior to administration of the CAPS, participants were asked three separate questions to assess the three facets of PTSD Criterion A2 in response to the event on the TLEQ that evoked the most distress—whether they were intensely afraid during the event, whether they felt helpless or powerless during the event, and whether they experienced horror at any time during the event.

Results

The mean period of elapsed time since the occurrence of the event for which PTSD was assessed was 7.9 years ($SD = 8.6$). For the 58 participants who were diagnosed with PTSD, the mean period of time since the occurrence of the event for which PTSD was assessed was 8.8 years ($SD = 8.7$). PTSD was in an acute phase (duration of symptoms less than 3 months) for only two of these participants (3%). Hence, PTSD was in the chronic phase (symptom duration of at least 3 months) for 97% of participants who had PTSD.

Reliability of A2 and PTSD Assessment

Interrater reliability assessments were conducted with 15% of the participants ($n = 30$) who received the CAPS. These assessments were conducted by a second rater (one of two psychologists) who sat in on 30 of the sessions in which CAPSs were administered by the psychology doctoral students.

Raters were in perfect agreement about participants' reports of Criterion A2. Raters agreed that 25 participants reported intense fear during the event(s), and five participants reported they did not experience intense fear. Similarly, raters agreed that 29 participants felt helpless or powerless during the event(s) and that one participant reported he did not feel helpless or powerless. Raters were in perfect agreement that 19 participants reported horror during the event(s), and 11 participants reported they did not experience horror during the event(s).

Raters also agreed perfectly about their classification of participants' PTSD status. Eight participants were classified by both raters as PTSD positive, and 22 participants were classified as PTSD negative by both raters. Ratings of participants' total symptom scores on the CAPS were correlated .97.

Number of A2 Responses Endorsed and PTSD Status

Ninety-three percent of participants ($n = 191$) met PTSD Criterion A2—defined as reporting at least one A2 response—intense fear, helplessness, or horror. Table 1 shows that (a) 56% of the sample ($n = 115$) reported all three A2 responses (intense fear, helplessness, and horror); (b) 22% of participants ($n = 46$)) reported two A2 responses, and (c) 15% of participants ($n = 30$) reported one A2 response (either intense fear, helplessness, or horror). Table 2 shows that PTSD was assessed for 20 different types of events. Sudden and unexpected death of a close friend or loved one was the most common event for which PTSD was assessed ($n = 51$; 25%).

As shown in Table 1, 43% of participants who reported all three A2 responses met full diagnostic criteria for PTSD. However, only 9% of participants who reported two A2 responses met diagnostic criteria for PTSD. Similarly, only 10% of participants who reported one A2 responses met diagnostic criteria for PTSD. A chi-square showing the relationship between PTSD status (present/absent) and number of A2 responses reported (1, 2, or 3) was highly significant, $\chi^2(2, N = 190) = 25.68$, $p < .01$.

Results shown in Table 3 indicate that the results were similar for male and female participants, across the four treatment settings, and by military/civilian status.

Number of A2 Responses Reported and Symptom Severity

Table 4 presents mean scores on the CAPS for participants who reported all three, two, one, and zero A2 responses. Analyses of variance were conducted on CAPS scores to examine whether PTSD symptom severity varied depending upon the number of facets of A2 endorsed. The overall F test was highly significant, $F(3, 201) = 16.78$, $p < .01$. Post hoc analyses revealed that PTSD symptoms were significantly more severe for participants who reported all three A2 responses than for participants who reported two A2 responses, for those who reported one A2 response, and for participants who did not report any A2 response. In addition, there were no differences in PTSD symptom severity on the CAPS among participants who reported two, one, or zero A2 responses.

Table 4 also presents mean scores on the PSDS, BDI, RSES, and Global Guilt scale. Analyses of variance conducted on PSDS, BDI, RSES, and Global Guilt scale scores were all highly significant. Participants who reported all three A2 responses obtained signif-

Table 1
Number of PTSD Criterion A2 Responses and Percentage of Participants With PTSD

No. of A2 responses reported	N	Participants with PTSD	Participants without PTSD	% of participants with PTSD
All three A2 responses (intense fear, helplessness, and horror)	115	50	65	43
Any two A2 responses	46	4	42	9
Any one A2 response	30	3	27	10

Note. $\chi^2 = 25.68$, $p < .01$. PTSD = posttraumatic stress disorder.

Table 2
Criterion A1 Events for Which PTSD Was Assessed

Type of event	% (*n*)
Sudden death of friend or loved one	25 (51)
Physically hurt by intimate partner	10 (21)
Growing up: Witnessed family violence	6 (13)
Growing up: Physically abused	6 (13)
Before 13: Sexual contact—someone 5 years older	5 (12)
Motor vehicle accident	4 (9)
As a teen: Unwanted sexual contact	3 (7)
As an adult: Unwanted sexual contact	3 (6)
Assaulted by acquaintance/stranger	3 (6)
Threatened with death/serious harm	3 (6)
Combat or warfare	3 (6)
Life-threatening/disabling event to loved one	3 (6)
Natural disaster	3 (6)
Abortion	3 (4)
Miscarriage	2 (3)
Before 13: Unwanted sexual contact	1 (2)
Stalked	1 (2)
Robbery/weapon used	0.5 (1)
"Other" type of accident	0.5 (1)
Witnessed severe assault to acquaintance/stranger	0.5 (1)
Some "other" traumatic event	13 (27)
None of these events happened to me	1 (2)

Note. $N = 205$. PTSD = posttraumatic stress disorder.

icantly higher BDI and Global Guilt scale scores than participants who reported fewer than three A2 responses. And participants who reported three A2 responses obtained significantly lower RSES scores than participants who reported fewer than three A2 responses. However, there were no significant differences on the PSDS, BDI, Global Guilt scale, or the RSES between participants who reported two, one, or zero A2 responses.

Discussion

The main findings of the present study are that 43% of participants who reported all three criterion A2 responses received a diagnosis of PTSD, whereas only 10% and 9% of participants who reported one or two A2 responses, respectively, received a diagnosis of PTSD. It is also noteworthy that rates of PTSD were not higher among participants who reported two A2 responses than participants who reported one A2 response. Participants who reported all three A2 responses were more than four times more likely to have PTSD than participants who reported two A2 responses, one A2 response or one and two A2 responses combined.

It may not be surprising that rates of PTSD were highest among participants who reported all three A2 responses. To the extent that the host response of intense distress predisposes an individual to develop posttraumatic symptoms, individuals who experience intense fear, helplessness, and horror would be expected to have had a more intensely negative or more traumatic reaction than individuals who experienced fewer than all three A2 responses. Also, consistent with findings of Breslau and Kessler (2001), almost no one who did not report any A2 response met symptomatic criteria for PTSD ($n = 1$; i.e., criteria B, C, and D).

A potential limitation of the study concerns the retrospective nature of participants' A2 reports. The A1 events for which participants reported their A2 responses occurred a mean 7.9 years ago. It is possible that participants with chronic PTSD were more likely to "remember" the index event as evoking intense fear, helplessness, and horror than participants who did not have PTSD. This explanation could have received support or been ruled out if the data had been collected prospectively, with participants initial reports of A2 contiguous in time with the events for which PTSD was assessed.

Another potential limitation of the study is that it was not designed to identify what is different about the responses of individuals who report all three A2 responses versus those who report fewer than three A2 responses. The results suggest that more participants who reported all three A2 responses had more PTSD because they were more traumatized by the events than individuals who reported fewer than three A2 responses. A certain threshold of emotional intensity may need to be reached or exceeded before a stressful event has the power to evoke a chronic posttraumatic stress reaction. However, the study was not designed to identify what was different about the emotional responses of individuals who reported all three A2 responses versus those who reported fewer than three A2 responses. Additional research is needed to investigate this issue. One potentially promising avenue of research would be to conduct structured clinical interviews with trauma survivors to explore nuances in the A2 response (cf., Kubany et al., 1996). For example, trauma survivors might be queried about what thoughts and feelings they experienced during the trauma. Such interviews might detect subtle qualitative differences in the responses of individuals who endorse all three facets of A2 versus those who endorse one or two facets of A2.

Table 3
Percentage and Proportion of Participants With PTSD Among Those Who Reported Three, Two, One, and Zero A2 Responses—by Gender, by Military/Civilian Status, and Across Treatment Settings

	Gender		Military/civilian status		Treatment setting			
No. of A2 responses reported	Men ($n = 73$)	Women ($n = 132$)	Civilian ($n = 109$)	Military personnel ($n = 96$)	Outpatient psychiatry ($n = 53$)	Alcohol abuse treatment ($n = 51$)	Domestic violence services ($n = 49$)	Primary medical care ($n = 52$)
Three	56% (20/36)	38% (30/79)	42% (28/66)	45% (22/49)	47% (18/38)	50% (12/24)	33% (13/39)	44% (7/23)
Any two	0% (0/18)	14% (4/28)	16% (4/25)	0% (0/21)	20% (2/10)	0% (0/11)	17% (2/12)	0% (0/13)
Any one	9% (1/12)	11% (2/18)	14% (2/14)	6% (1/16)	25% (1/4)	0% (0/8)	05 (0/7)	05 (0/11)
Zero	0% (0/7)	14% (1/7)	25% (1/3)	0% (0/10)	0% (0/1)	0% (0/7)	—	0% (0/5)

Note. PTSD = posttraumatic stress disorder.

Table 4
Scores on the CAPS, PSDS, BDI, RSES, and the TRGI Global Guilt Scale of Participants Reporting Three, Two, One, and Zero Criterion Responses (Intense Fear, Helplessness, Horror in Response to the Event)

No. of criterion A2 responses reported	*n*	CAPS		PSDS		BDI		RSES[a]		Global Guilt Scale	
		M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Three	115	37.6_a	27.0	26.3	19.0	17.8_a	1.0	16.9_a	27.0	1.7_a	0.1
Any two	46	16.2_b	20.9	12.7	15.6	9.1_b	1.5	21.3_b	20.9	1.0_b	0.2
Any one	30	15.7_b	18.8	13.2	15.4	8.6_b	1.9	22.3_b	18.8	0.8_b	0.2
Zero	14	7.9_b	16.3	3.9	6.4	4.2_b	2.9	25.9_b	16.3	0.6_b	0.3

Note. The A2 criterion are intense fear, helplessness, and horror. For each scale, means with different subscripts differ significantly at $p < .01$, two-tailed (Bonferroni adjusted). CAPS = Clinician Administered PTSD Scale; PSDS = PTSD Screening and Diagnostic Scale; BDI = Beck Depression Inventory; RSES = Rosenberg Self-Esteem Scale; TRGI = Trauma-Related Guilt Inventory; PTSD = posttraumatic stress disorder.
[a] RSES scores were ordered to range from 0 to 30 (high self-esteem).

The results of this study were highly significant, lending support to the study's internal validity. Internal validity was further supported by the large differences in psychopathology other than PTSD between participants who reported all three A2 responses compared to those who reported fewer than two A2 responses (e.g., higher BDI scores). Reports of all three A2 responses were associated with overall poorer psychological functioning as well as with posttraumatic stress.

The findings may have external validity in that they may apply to treatment-seeking populations in general. We obtained very similar results across gender and in samples of participants receiving services from four different treatment programs—alcohol abuse treatment, family violence services, outpatient psychiatry, and primary medical care. For example, between 40% and 54% of participants from each of these four clinical settings who reported all three A2 responses received diagnoses of PTSD. By contrast, only 0% to 20% of participants from the four treatment settings who reported fewer than three A2 responses had PTSD.

The results are not presumed to generalize to the general population at large, who are not treatment seeking. Future research is needed to determine whether to what extent the results generalize to the general population at large.

More important, the results of this study apply primarily to the PPV of the A2 criterion as it relates to chronic PTSD, because almost all participants with CAPS-diagnosed PTSD had symptoms for more than 3 months (56/58). Hence, the results suggest that predicting which individuals are most likely to develop chronic PTSD may be best made on the basis of which individuals report all three A2 responses. It will be necessary to conduct a prospective or longitudinal study to confirm this hypothesis.

The results may also have some practical implications. In any setting, trauma history/PTSD screening can be labor intensive. The process of identifying individuals with chronic PTSD may be most efficient if follow-up PTSD evaluations are only conducted with individuals who answer "yes" to the following three probes about PTSD criterion A2: (a) "Did you experience intense fear during the event?" (b) "Did you feel helpless or powerless during the event?" and (b) "Did you experience horror during the event?" To the extent that the results of this study apply to other treatment settings, follow-up PTSD assessments can be focused primarily on patients who report all three A2 responses, with only a minor loss in detection of individuals who have PTSD. To use the data from the present study as an illustration, 91% of those individuals having PTSD could have been identified if the CAPS was only administered to participants who endorsed all three A2 responses. (Only 9% of individuals who reported fewer than two A2 responses had PTSD.) Thus, the present findings may have important practical implications when resources are limited or it is impractical to conduct PTSD evaluations with all affected persons.

The results may also have implications for reevaluating the criteria for making a PTSD diagnosis. The results suggest that the *DSM–IV* definition of PTSD criterion A2 may be too broad. For a significant number of individuals, only reports of all three A2 responses may represent a sufficiently intense psychobiological response that is predictive of chronic PTSD. Thus, a revision or refinement of the current criterion A2 in the next edition of the *DSM* may be indicated (Kupfer, First, & Regier, 2002). As a starting point for revision consideration, it may be more appropriate to define PTSD Criterion A2 as, "intense fear, helplessness, *and* [emphasis added] horror." However, because a revision of PTSD Criterion A2 would have far-reaching practical consequences, it would be important to replicate the present findings before any final decision were made to revise Criterion A2.

The issue has been raised as to whether the A2 criterion should be broadened to include other emotions, such as shame, guilt, or anger (Rubin, Berntsen, & Bohni, 2008) although little research has been conducted to investigate the role of negative emotions other than intense fear, helplessness, or horror. Investigation of the role of other emotions in predicting PTSD symptomatology is beyond the scope of the present study and awaits investigation in future research.

References

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., revised). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Beck. A. T., Steer. R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8,* 77–100.

Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Klauminzer, G., Charney, D. S., & Keane, M. (1990). A clinician rating scale for assessing current and lifetime PTSD: The CAPS–1. *Behavior Therapist, 13,* 187–188.

Breslau, N., & Kessler, R. C. (2001). The stressor criterion in *DSM–IV* posttraumatic stress disorder: An empirical investigation. *Biological Psychiatry, 50,* 699–704.

Brewin, C. R., Andrews, B., & Rose, S. (2000). Fear, helplessness, and horror in posttraumatic stress disorder: Investigating *DSM–IV* Criterion A2 in victims of violent crime. *Journal of Traumatic Stress, 13,* 499–599.

Brewin, C. R., Andrews, B., & Rose, S. (2003). Diagnostic overlap between acute stress disorder and PTSD in victims of violent crime. *American Journal of Psychiatry, 160,* 783–785.

Falsetti, S. A., Resnick, H. S., Resick, P. A., & Kilpatrick, D. G. (1993). The modified PTSD Symptom Scale: A brief self-report measure of posttraumatic stress disorder. *The Behavior Therapist, 16,* 161–162.

Kubany, E. S., Haynes, S. N., Abueg, F. R., Manke, F. P., Brennan, J. M., & Stahura, C. (1996). Development and validation of the Trauma-Related Guilt Inventory (TRGI). *Psychological Assessment, 8,* 428–444.

Kubany, E. S., Haynes, S. N., Leisen, M. B., Owens, J. A., Kaplan, A., & Burns, K. (2000). Development and preliminary validation of the Traumatic Life Events Questionnaire. *Psychological Assessment, 12,* 210–224.

Kubany, E. S., & Hill, E. E. (2004). Development and Validation of a Computerized Trauma History/PTSD Screen. Poster presented at the 2004 Annual Convention of the American Psychological Association, Honolulu, HI.

Kubany, E. S., Hill, E. E., & Haynes, S. N. (1998). *Development and validation of a computerized trauma history/PTSD screen.* Grant funded by the Health Services Research & Development program, Department of Veterans Affairs.

Kubany, E. S., Leisen, M. B., Kaplan, A. K., & Kelly, M. (2000). Validation of the Distressing Event Questionnaire (DEQ): A brief diagnostic measure of postraumatic stress disorder. *Psychological Assessment, 12,* 192–209.

Kupfer, D. J., First, M. B., & Regier, D. A. (Eds.). (2002). *A research agenda for* DSM–V. Arlington, VA: American Psychiatric.

Roemer, L., Orsillo, S. M., Borkovec, T. D., & Litz, B. T. (1998). Emotional response at the time of a potentially traumatizing event and PTSD symtomatology: A preliminary retrospective analysis of the *DSM–IV* Criterion A2. *Journal of Behavior Therapy and Experimental Psychiatry, 29,* 123–130.

Rubin, D. C., Berntsen, D., & Bohni, M. K. (2008). A memory-based model of posttraumatic stress disorder: Evaluating basic assumptions underlying the PTSD diagnosis. *Psychological Review, 115,* 985–1011.

Weathers, F. W., Blake, D. D., Krinsley, K. E., Haddad, W., Huska, J. A., & Keane, T. M. (1992, November). *The Clinician-Administered PTSD Scale: Reliability and construct validity.* Poster presented at AABT 26th annual convention, Boston, MA.

Western Psychological Services. (2003). *PTSD Screening and Diagnostic Scale (PSDS) [formerly Distressing Event Questionnaire (DEQ)].* Beverly Hills, CA: Author.

Western Psychological Services. (2003). *The Traumatic Life Events Questionnaire (TLEQ).* Beverly Hills, CA.

Zoellner, L. A., Jaycox, L. H., Watlington, C. G., & Foa, E. B. (2003). Are the dissociative criteria in ASD useful? *Journal of Traumatic Stress, 16,* 341–350.

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